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| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500  Post Office Box 1715  Columbia, South Carolina 29202-1715  (803) 737.5675 [www.wcc.sc.gov](http://www.wcc.sc.gov) | | | SCSealBWjpg | | | |  |  | | --- | --- | | WCC File #: |  | |  |  | | Carrier File #: |  | |  |  | | Carrier Code #: |  | |  |  | | Employer FEIN #: |  | |  |  | | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | SSN: | | -    - | | |  | |  | | | | | | | | | Address: | |  | | | | | | | | |  |  | | |  |  | |  | |  | | City: |  | | | State: |  | | Zip: | |  |  |  |  |  |  | | --- | --- | --- | --- | | Home Phone: | (     )     - | Work Phone: | (     )     - | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  | | --- | --- | | Insurance Carrier: |  | | | | |
| Preparer’s Name: |  | Law Firm: | |  | | | Preparer’s Phone #: | (     )     - |
|  |  |  | |  | | |  |  |

The date of injury reported on Form 12A is:      (m/d/yyyy)

**Check appropriate section(s). The Employer’s Representative requests a hearing to:**

1. **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer’s representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on      (m/d/yyyy) (copy of medical report must be attached).

Compensation payments are current as of       (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.

A Form 17 was offered and refused on       (m/d/yyyy).

1. **Address suspension, termination, or reduction of temporary disability payments for any cause.**

a. At any time pursuant to § 42-9-260(E).

b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is

1. **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

Claimant reached maximum medical improvement on      (m/d/yyyy) (copy of medical report must be attached).

1. **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**
2. **Determine amount of compensation for claims involving a fatality.**

a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.

b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

1. **Mediation**

a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.

b. Mediation is required pursuant to Reg. 67-1802.

c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Failure to respond pursuant to Reg. 67-208 B in writing may result in ordered mediation pursuant to Reg. 67-1801 B.

Questions regarding mediation may be submitted to [**mediation@wcc.sc.gov**](mailto:mediation@wcc.sc.gov).

**I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to**

**Address on the** **day of** **20****, by:**

**first class postage**  **certified mail**  **personal service  electronic service. A $50.00 filing fee and updated Form 18 is required.**

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| Preparer’s Signature |  | Title |  | Email |  | Date |